INTERNATIONAL RESERVE POLICE OFFICER ASSOCIATION EXCHANGE PROGRAM

HON. JOE KNOLLENBERG

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Wednesday, July 26, 2000

Mr. KNOLLENBERG. Mr. Speaker, I rise today to recognize and commend the International Reserve Police Officer Association Exchange Program. This program provides a unique opportunity for reserve police officers from American cities and towns to share information and go on patrol with their counterparts in other nations. The Association allows for the open exchange of reserve policing concepts between countries and between individual reserve officers.

This year marks the fifth year of the International Reserve Police Officer Association exchange program. Their 2000 international conference will be held in the United Kingdom. Officers from my home state of Michigan representing the Oakland County Sheriff's Department, Waterford Township and the City of Dearborn will visit Wales and England in August. The reserve police officers will patrol with both regular and special officers of the South Wales Constabulary, the Metropolitan Police and the City of London. A formal conference will be held on August 31 at New Scotland Yard.

I wish to extend to each officer, from both America and the United Kingdom, my sincere appreciation for their efforts in strengthening the bond of friendship and professionalism among reserve police officers. These individuals risk life and limb every day by volunteering their services to the public. Their dedication and hard work in protecting the public are to be enthusiastically saluted.

ON THE INTRODUCTION OF THE COMMUNITY ACCESS TO HEALTH CARE ACT OF 2000

HON. GENE GREEN

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, July 26, 2000

Mr. GREEN of Texas. Mr. Speaker, I rise today in support of the Community Access to Health Care Act of 2000, legislation I am introducing to help our states and communities deal with the crisis of the uninsured.

Over 44 million Americans do not have health insurance and this number is increasing by over a million persons a year. Most of the uninsured are working people and their children—nearly 74 percent are families with full-time workers. Ten percent of the uninsured are in families with at least one part-time worker. Low income Americans, those who earn less than 200% of the federal poverty level or $27,300 for a family of three, are the most likely to be uninsured.

Texas is a leader nationally in the number of uninsured, ranking second only to Arizona. About 4 million persons, or 26.8 percent of our non-elderly population, are without insurance.

The uninsured and under-insured tend to be more expensive to care for. They fall through the health care cracks. They put off going to a doctor until it is too late—and then they go to the emergency room. Instead of having available the wide variety of preventive measures and checkups that those of us with insurance take for granted, the uninsured often ignore the symptoms of what might be larger problems because they simply cannot afford to go to the doctor.

According to research done by the Kaiser Family Foundation, nearly 40% of uninsured adults skip a recommended medical test or treatment, and 20% say they have needed but not gotten care for a serious problem in the past year.

Uninsured children are at least 70% less likely, Kaiser reports, to receive preventive care. Uninsured adults are over 30% less likely to have had a check-up in the past year, uninsured men 40% less likely to have had a prostate exam and uninsured women 60% less likely to have had a mammograrm than compared to the insured.

The uninsured are at least 50% more likely than the insured to be hospitalized for conditions such as pneumonia and diabetes. Unfortunately, the uninsured are more likely to be diagnosed with fatal diseases at significantly later stages than are those with insurance. Death rates from breast cancer are higher for the uninsured than for those with insurance.

In many American cities, towns and rural areas, there is general agreement that—something needs to be done to track, monitor and serve the uninsured. We all pick up the tab for the uninsured in the end—why not have communities join forces to attack this problem on a local level? Why not spend our tax dollars wisely and invest in prevention rather than spend them foolishly paying for emergency room visits or lengthy hospitalizations?

The Community Access Program (CAP) embodies this idea; it stems from a very successful Robert Wood Johnson Foundation-funded project that showed that community collaboration increased access to quality, cost-effective health care. Last year, the Clinton Administration proposed and Congress passed the Community Access Program as a $25 million demonstration effort. This year, over 200 applications were received for approximately 20 grants. Obviously, the need for and the interest in this program is great.

The Community Access to Health Care Act of 2000 will authorize the Community Access Program for five years. It gives competitive grants to communities to help more uninsured people receive health care and to ensure that communities join forces to map a strategy for counting and dealing with the uninsured.

Funding under CAP can be used to support a variety of projects to improve access for all levels of care for the uninsured and under-insured. Each community designs a program that best addresses the needs of the uninsured and under insured and the providers in their community. Funding is intended to encourage safety net providers to develop coordinated care systems for the target population.

The majority of the CAP funds will be used to support expenses for planning and developing an integrated health care delivery system. A small portion of the funds may be used for direct patient care if there are gaps to putting together an integrated delivery system.

Applications for the CAP demonstration project were due this past June; 208 were submitted by groups from 46 states and the District of Columbia. Applications were evenly distributed between urban and rural areas, and six were submitted by tribal organizations. About three fourths of applications came from communities with rates of uninsured persons higher than the national average of 14%. Half of applications came from communities with rates of uninsured persons greater than 20%. Close to 90% of applications target all uninsured persons in an area.

Perhaps the best way of explaining how CAP can improve a community's health care networking is to paraphrase from the application submitted from a group in Houston. The lead applicant, Harris County, is the third most populated county in the nation and the most populated county in Texas with about 3.2 million residents. Close to 50% of our residents are Anglo, about 18% are African American, about 27% are Hispanic and about 5% are Asian. The Asian population is the fastest growing, followed by Hispanics and African Americans.

According to Harris County's proposal, "population growth and an economic boom have enhanced the overall wealth and employment opportunities of the community. It has, however, also resulted in greater economic disparities between the privileged and the economically disadvantaged. The numbers of uninsured and under insured are on the rise."

The Texas Health and Human Services Commission estimated that in 1999, 25.5% of the total population in Harris County—834,867—was uninsured. Of this total number, the applicants have targeted three populations: First, they will target those with incomes under 200% of the federal poverty level (428,369 persons). Second, they will target those with incomes over 200% of the federal poverty level (301,000 persons). Third, they win target those who are under insured (328,183 persons).

According to Harris County, the primary focus of this project is to improve the interagency communication and referral infrastructure of major health care systems in the city. This will improve their ability to provide preventive, primary and emergency clinical health services in an integrated and coordinated manner for the uninsured and under insured population. Harris County will place particular emphasis on the development and/or enhancement of the existing local infrastructure and necessary information systems.

In addition to expanding the number and type of providers who participate in collaborative care giving efforts, Harris County would establish a clearinghouse for local resources, care navigation and telephone triage to increase accessibility and reduce emergency room care. The clearinghouse will receive referrals of uninsured patients from health service providers and patient self-referrals. The consortia will give special attention to health disparities in minority groups. It will establish a database for monitoring, tracking, care navigation and evaluation. In Harris County, it is expected that this initial support from grant funds would become self-sustained through contributions from participating providers, especially smaller primary care providers who can rely